December 20, 2005
Addendum No. 1
To
Request for Proposals
Crisis Network Services
RFP HTH 501-1

The Department of Health, Developmental Disabilities Division, Case Management and Information Services Branch, is issuing this addendum to HTH 501-1, Crisis Network Services, for the purposes of:

☒ Responding to questions that arose at the orientation meeting of December 1, 2005, and written questions subsequently submitted in accordance with Section 1-V, of the RFP.

☒ Amending the RFP.

The proposal submittal deadline:

☐ is amended to <new date>.

☒ is not amended.

Enclosed is (are):

☒ A summary of the questions raised and responses for purposes of clarification of the RFP requirements.

☒ Amendments to the RFP.

Should you have any questions, contact:

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HTH 501-1, Crisis Network Services, is amended as follows:

Section 2, Service Specifications, page 2-3:

I. Introduction

E. Probable funding amounts, source, and period of availability

Approximate State funding: $1.6 million for the period March 2006, the planned contract start date, or Notice to Proceed, whichever is later, through June 2007, subject to availability of State funds.

Section 2, Service Specifications, page 2-21 and 2-22:

III. Scope of Work

B. Management Requirements

8. Pricing structure or pricing methodology to be used

The pricing structure for service activity areas "a" through "e" shall generally be based on fixed unit rate. The pricing structure for service activity area "f" shall be based on cost reimbursement. The allotments for each of the service activity areas are estimates.

a.	Crisis Network, Training and Consultation Services: Training and Consultation for Individuals: Estimated $155,556 allotted
b.	Crisis Outreach Services: Estimated $20,235 allotted
c.	Crisis Shelter Services: Estimated $440,920 allotted
d.	Crisis Respite Services for Adults: Estimated $242,296 allotted
e.	Residential Habilitation Services: Estimated $363,375 allotted for adults Estimated $117,165 allotted for children
f.	System Coordination: Estimated $222,222 allotted Cost reimbursement for the contract period

9. Units of service and unit rate

a.	Crisis Network, Training and Consultation Services: Fixed unit rate of $200/hour Training and Consultation for Individuals: $126.44/hour MD/psychiatrist $80.84/hour Psychologist $58.08/hour Dietician $64.68/hour RN $51.72/hour Behaviorist $87.92/hour Speech $92.12/hour Pharmacist
b.	Crisis Outreach Services: Fixed unit rate of $79.16/hour
c.	Crisis Shelter Services: Fixed unit rate of $453.25 /day
d.	Crisis Respite Services for Adults: Fixed unit rate of $223.17/day
e.	Residential Habilitation Services: Fixed unit rate of $187.50/day Residential Habilitation Services for Children: Fixed unit rate of $294.50/day
f.	System Coordination: Cost reimbursement amount of $222,222 for the contract period.

Responses to Questions Raised by Applicants
For RFP HTH 501-1, Crisis Network Services
December 20, 2005

Question #1: The document states that $1.4M is available for award, yet the amounts of service expected total $1.75M. Can you please explain the difference?

Response #1: DDD has reviewed the probable funding amounts and the pricing structure amount of funding listed in the RFP on page 2-21 and will be issuing an addendum. The discrepancy was due to the allocations being based on 18 months of service (original planned contract start date of January 2006). Since the contract is now expected to commence in March 2006, 1.6 million will be contracted.

Please refer to the Addendum #1 above.

Question #2: Can you please clarify how the flat rate system vs. specific provider rates works? We think this means that you bill the specific rate identified for the professional when working with or on behalf of an individual and when doing "system services" – general training and consultation, you bill the fixed $200/hr rate.

Response #2: Under this RFP, the Crisis Network development is a key activity. System Coordination activities are billed at the $200/hour rate. These services would not be billable under the Medicaid Waiver. For Training and Consultation for Individuals, the specific fixed rates would be applicable and billable under the Medicaid Waiver.

Question #3: What scope of services must be available on the neighbor islands within what time frames (for example, it may be very possible to have a crisis respite bed available on one of the neighbor islands within 30 minutes but it may take 3 hours for a licensed psychologist to be available)?

Response #3: Section 3, Proposal Application Instructions, and Section 4, Proposal Evaluation, of the RFP describes Service Delivery areas that applicants should respond to. Section 2, Service Specifications, describe the array of services required. In general, Crisis Outreach is the service where immediate response is required. We do not expect a licensed psychologist to be available onsite, but the psychologist should be available for consultation, as stated on page 2-17.

Question #4: How many people are we talking about needing to support? How many are kids and how many are adults? Do we know the specific numbers, ages, and anticipated needs on each of the neighbor islands? (So that we can determine how to allocate resources, plans for inter-island transportation, etc.)

Response #4: The DDD used an informal poll to come up with the estimated number of individuals to be served for each of the services. These estimates were used to base the stated allocation in the services listed on page 2-21 and 2-22 and are:

Crisis Outreach: 80 individuals statewide, 1/3 or 26 individuals non-Medicaid
Crisis Respite for Adults: 6, 1/3 or 2 individuals non-Medicaid
Crisis Shelter: 6, 1/3 or 2 individuals non-Medicaid
Residential Habilitation for Adults: 18, 1/3 or 6 individuals non-Medicaid
Residential Habilitation for Children: 5

DDD does not know specific (actual) numbers, ages and anticipated needs. In general, it is predicted that 7 percent of clients will be on the neighbor islands, across Kauai, Maui and Hawaii. The CNS provider must bill the Medicaid Waiver for individuals that are eligible for services under the Medicaid Waiver; therefore, budgets should reflect services for individuals who are non-Medicaid and services not billable under the Medicaid Waiver. DDD expects that one of the outcomes for the Crisis Network is to find out what the needs are.

Question #5: Is it accurate that you want 3 crisis respite beds for adults the first year (July 1-Dec 31, 2006) and 6 beds the second year? Do you have similar parameters for other services? (Is there a preference for the order, or established timeline, for the initiation of specific services?)

Response #5: Yes. DDD must continue Residential Habilitation for Children and Residential Habilitation for Adults. The Residential Habilitation for Adults timeline is 6 beds for the first year (March 2006-June 30, 2006), 12 beds in the second year, from July 1, 2006 until June 30, 2007. Currently DDD has certified 2 Adult Foster Home beds that would qualify for Residential Habilitation for Adults that the CNS provider can assume responsibility for; a third bed is currently pending certification. The Residential Habilitation for Children timeline is July 1, 2006; currently DDD has one Special Treatment Facility that is licensed for 5 beds; the CNS provider and the DDD must assure continuity of services for these children.

Applicants can propose a strategy for a timeline in their proposal that meet the goals of the service, as stated on page 2-2.

Question #6: Does the submission need to be by a currently approved waiver provider or is it sufficient to certify that we agree to become a waiver provider once the RFP is awarded?

Response #6: As stated on page 2-3, DDD is looking for a provider that is a Medicaid Waiver provider in order to maximize state funds and provide a seamless statewide system of supports. Therefore, if you are not a current waiver provider, a separate proposal application needs to be submitted to become a waiver provider. The proposal application can be obtained from Marge Sheehan, DDD.

Question #7: It was mentioned on the conference call "ITEMS 1-6 ARE PRE-PAID, ITEM 7 IS COST REIMBURSEMENT". Does that mean the winning bid will get the money in advance so that we do not have to borrow money while we are waiting to get paid?

Response #7: For services based on a fixed unit rate pricing structure, compensation will be for actual units served. There is no pre-payment of funds, however, there will be a first quarter advance for the System Coordination and, thereafter, monthly payments for System Coordination. For System Coordination a cost reimbursement pricing structure will be used. This means that for cost reimbursement, the provider will be compensated for approved budgeted cost items that are actually incurred in delivery of services up to the approved budgeted amount.

See attached summary of the RFP Orientation for further clarification.

Question #8: Are there currently facilities identified that are licensed and/or otherwise available for easy licensure (e.g.: state owned/leased)?

Response #8: No, there are no identified facilities that are licensed and/or otherwise available for easy licensure. There are no state-owned /leased facilities.

Question #9: We have not yet completed our first year as a company under our new configuration (we have consolidated to formerly smaller organizations). What should we do regarding the tax submission since neither would be reflective of the current situation and neither would have the current company name?

Response #9: DDD has consulted with our Deputy Attorney General (DAG) for a response on this question, as recommended by our State Procurement Office. Unfortunately, DDD has not received a reply from our DAG. A response when received will be furnished as a written clarification.

Question #10: What is the administrative overhead allowance?

Response #10: There is no set administrative rate. Cost proposals (budgets) for the fixed unit rate and cost reimbursement activities must fully support the scope of services and requirements of the RFP. Budgets must be reasonable based on program resources and operational capacity.

Question #11: Admittedly we have not reviewed all of the forms in great detail yet, but we have not seen an explanation of "After the fact secondary purchases will be allowed". Can you please explain this?

Response #11: This is templated RFP language based on the Hawaii Administrative Rules (HAR) 3-143-608 which states: Secondary purchase of competitive purchase of service. (a) In order to increase the efficiency of health and human services procurements through better planning, purchasing agencies may coordinate purchase of similar health and human services by combining their requirements as primary and secondary purchases of health and human services as provided herein: (1) After-the-fact secondary purchase. A purchasing agency may utilize the service or part of the service that has already been procured under a competitive purchase of service by another purchasing agency.

DDD has no planned secondary purchases.

Question #12: The provider is expected "to evaluate all referred individuals to determine if a crisis indeed exists." Does this criteria already exist and, if so, can we get a copy? We are trying to figure out who can determine that a crisis exists, how this must be done, and how we can prevent providers from "dumping" or creating/expanding a crisis in order to be relieved of their responsibilities.

Response #12: Section 2, Service Specifications, III. Scope of Work, A. Service Activities, 3. Crisis Outreach Services, on page 2-8 defines crisis as "situations in which the individual's presence in their home or program is at risk due to the display of challenging behaviors that occur with intensity, duration and frequency that endangers his or her safety or the safety of others, or results in the destruction of property". There is no assurance to prevent providers and others from "dumping"; DDD believes the emphasis on the Crisis Network will result in capacity building, mutual support, collaborative best practices, etc.

Question #13: One major cost for many crisis programs is extended stays past the acute phase because the former provider will not accept their return. Who is

responsible for assuring the individual has residential services at discharge? What is the CNS provider's responsibility if no one is available to provide the adequate and necessary services when they no longer need "crisis" residential supports?

Response #13: The DOH case manager is responsible for coordinating residential services at discharge while the provider would work with DOH case manager to complete discharge. The CNS provider would probably be part of the circle to assist in getting needed services in place; the DOH case manager has the responsibility to assure adequate and necessary services are in place.

Question #14: Who is responsible for enforcing compliance with the crisis prevention/early intervention plans?

Response #14: The provider is responsible to some degree; there should be mutual interest in compliance with crisis prevention/intervention plans. For the CNS provider, there would be prerequisite assurance of training of staff by the CNS provider. The DOH case manager oversees coordination of services and monitors overall services, however, the guardian has ultimate responsibility for the individual's Individualized Service Plan.

Question #15: Could a psychologist approve curriculum outside of Hawaii or must one in Hawaii be used to approve and supervise training?

Response #15: DDD will accept a psychologist licensed outside of Hawaii to approve curriculum, however, for any direct services to clients, the psychologist must be licensed in Hawaii.

REQUEST FOR PROPOSAL ORIENTATION SUMMARY
RFP HTH 501-1, CRISIS NETWORK SERVICES
December 1, 2005

Questions	Response/Comments
	Welcome and Introductions - Marge Purpose of Orientation - Marge 1. To cover RFP content and procurement process; 2. For DOH/DDD, CNS is a new service we are buying so we are going to defer any operational type questions to be addressed at a later date; 3. A written summary of today's meeting will be distributed; 4. Today's meeting is being tape recorded; 5. RFP Interest Form needs to be downloaded.
	Agenda 1. Background - Mike 2. Service Activities - Marge 3. Pricing Structure - Glenn 4. Questions and Answers
	Historically, DOH was the primary provider of crisis services: institution for individuals with developmental disabilities/mental retardation, operated day program and crisis shelter, provided crisis outreach and operated community homes. This was done until 1999 when the State institution was closed in Hawaii and gradually provision of direct services was phased out based on the concept that the Department needed to focus on its public health role of assessment, policy and assurance functions. Gradually, those functions were shifted out to the private sector. In order to fund this, services were incorporated within the waiver. We (DOH) found lack of capacity in system in picking up services; some agencies were willing to provide some portions of the services. Two years ago, DDD issued a contract with NASDDDS (Chas Mosley and Michael Smull) to do an assessment and provide recommendations on how to improve our system. ▪ Concepts from Chas Mosley: build capacity of network through emphasis on training and consultation for stakeholders ▪ Concepts for Michael Smull: look at individuals, person-centered planning process Concepts incorporated into RFP: emphasize building network capacity through training and consultation to individuals, prevention-based model, (also) recognize that when people need help they cannot wait two months to get help (24/7 availability), (and need for) Statewide services (80 percent of population is based on island of Oahu).

Questions	Response/Comments
Question on dual diagnosis; going beyond the DD population.	Initially started looking at individuals in Hawaii State Hospital (HSH), oversight by Federal government. The big push was to get individuals with developmental disabilities/mental illness into community settings rather than stay in HSH. This was one of the issues we were concerned about; large part of our population are those with developmental disabilities with challenging behaviors. Focus on both. Comment on target population: currently in Hawaii, we do not have a crisis shelter. When the State closed this service, very few providers were interested in taking over. We had one provider but service ended a couple of months ago. (This was) another reason why we approached Legislature to get more money to build a service that was more prevention-based. Recognize that in some cases, still need a crisis shelter and that is why crisis shelter is still part of the package.
	Service Activities Scope of Work, page 2-5 Emphasize prevention model of service. <u>Crisis Network (page 2-5):</u> Our vision is to have monthly meetings to develop capacity; include families and other providers. Provider to be responsible to convene the meeting. DDD would help and steer the service. Some topics for training and train-the-trainer approach are listed on page 2-6. Maximize State funds: looking for a provider that is already a Home and Community Based Services (HCBS) waiver provider. For those providers who already provide HCBS waiver services, this training and crisis network piece would not be available in the waiver, therefore, we are putting some (an) allotment of money here. We see this piece as helping everyone to build capacity. This is a new direction for us; see this as an instrumental part in how we bring up capacity in the service. Your RFP proposal should emphasize the strategy and plan to meet the goal.
	<u>Training and Consultation for Individuals (page 2-7):</u> In the current waiver, we have this piece and it is called Specialized Services. Under Specialized Services, we have many disciplines that qualified agencies can provide to individuals that need short term, intermittent, training and consultation. Tandem service with Crisis Network; you would simultaneously do Training and Consultation for Individuals for specific situations. Page 2-7 lists disciplines to be utilized for individuals with challenging behaviors. Some of the rates will probably increase. We recognize that behavioral specialist is low. Looking at increasing those rates in July 2006.

Questions	Response/Comments
	Crisis Outreach, page 2-8: Basically, we are asking for 24/7availability. We used the word "availability" because we want to be flexible in saying how you do (operationalize) the availability for families and others; may result in partnership with another part of DOH or among providers. The goal is to allow families and caregivers call 24/7 and get help.
	Crisis Shelter, page 2-9: Per diem; daily rate. All services are inclusive. If person is in shelter, you cannot bring in any additional services; all services built into the rate. Looking at increasing rate July 2006. On page 2-11, contrary to the current crisis shelter standards, we are putting in a change in length of stay to 90 consecutive days. Must be licensed Special Treatment Facility (STF).
	Crisis Respite Service for Adults, page 2-12: Effort to provide Statewide services, especially for neighbor islands, not feasible to set up a crisis shelter on the neighbor islands so crisis shelter "bed" will meet need. Not to exceed 14 day stay.
	Residential Habilitation for Children, page 2-13: Effective July 2006. We have current contract with private provider for 3 children, we want this service to continue. We will not prescribe how the provider provide service but may have provider work with current provider. We have children with challenging behaviors; do not have a residential component. Intertwined with Department of Education and their requirements. See this as a need but want to start small.
For Residential Habilitation for Adults, specified 18 beds but for Residential Habilitation for Children, nothing is specified.	Residential Habilitation for Adults, page 2-15: New service for Medicaid waiver for July 2006. Currently, there are 2 "behavioral homes". These homes have 2 adult individuals with challenging behaviors. These homes are Adult Foster Homes (AFH) that received extra training and for this receive extra compensation. Responsible for all activities listed. We are looking to continue residential setting for the 3 children we have now. Very complex issue since it involves child placement responsibilities and while we have started some dialogue with other agencies in our State, we have not come to an agreement.
	Pricing Structure, pages 2-21 and 2-22: There are 7 service activity areas (6 of these on a fixed unit rate, 7th will be based on cost reimbursement). It is required that proposals be submitted with a budget for each of

Questions	Response/Comments
	the services activity areas; we will be looking for 7 budgets in the proposal. As far as the number of people to be served for Crisis Outreach service activities, we are going to be funding non-waiver clients with this contract. If the clients are waiver, you will be billing the waiver. One third (1/3) of the clients served for Crisis Outreach services will be non-waiver clients. For Crisis Shelter services, approximately 2 non-waiver clients. For Crisis Respite Services for Adults, 1st year, 3 beds; 2nd year, 6 beds. In the 1st year, we will be funding all the participants since Crisis Respite services will not be up until July for waiver.
Possibility of rates going up in several areas, ready to indicate where they might go?	We have not begun new rate setting yet. We have looked at new services we are going to add like Crisis Respite and Residential Habilitation and we know levels but have not attached rates. For behavioral specialist and psychiatrist, we will be looking at comparing rates to market rates but have not done that yet. We have walked through a prediction on utilization of services. We do expect that a large part of the services will be billed through the Medicaid waiver such as Crisis Outreach and Specialized Services.
When you rate your proposals and assign rate factors, assume that provider that can do the majority of services will get a higher rating, right?	For rating of proposals, we put the points in the evaluation criteria section. We are looking for that "statewideness"; coordination piece.
And so if you don't get a proposal that incorporates all of the factors, would you look at craving out and renegotiating for those kinds of services? Appears that when the proposal has been written you'd try to incorporate some successful existing programs within the structure that you want the provider to subsume into their proposal or into their management of their program. But if there are some that can do parts of that picture, do they have to build it into their total package or can they start to carve out and hope that when you get all the proposals, you can build on that capacity? Or is that out of the question and if you don't find one provider to meet all your needs, you're going to say goodbye?	Addressed in the evaluation section. We are looking at, first and foremost, a provider that can do the whole array of services statewide. But if not, in your proposal, you should indicate what you can provide and indicate if you have any kind of agreements with other providers to come in as a group and/or willingness to work with others. The State's position is that we are going to try to procure the best service possible for what our goal in the service is. We recognize the lack of services and resources on the neighbor islands so by not requiring a provider to do statewide services, we would continue to foster a lack of development of services on the neighbor islands. We would like to have one provider do everything statewide because it would be easier in terms of consistency and availability of services. If that is not the case, we will look at other options.

Questions	Response/Comments
For neighbor islands, partnership is important; small percentage (20%) on the neighbor islands.	We would like to have one provider but if proposals come in for certain services or certain geographical areas, we would take a look at it. For clarification on page 2-22, Item F, System Coordination, those funds would go only if there is one system-wide provider. If providers chunk it out, that is (system coordination) not included. Cost reimbursement pricing structure is to recognize that there will be some start-up costs for the different pieces of services.
	State will be distributing summary of orientation. Deadline for questions is December 9, 2005; State will be issuing written responses to the questions according to the timeline. State will be distributing the written summary simultaneously with the written questions. Timelines should be reviewed by all. Some deadlines are non-negotiable; especially for mainland, note that the RFP deadline is a mail-in deadline. RFP Interest Form should be completed by all those who downloaded the RFP from the website.